STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185159	A. BUILDING _____ B. WING _____	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKFORT	117 OLD SOLDIERS LANE FRANKFORT, KY 40601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED An Abbreviated Survey investigating KY#00023294 and KY#00023315 was initiated on 06/01/15 and concluded on 06/04/15. KY#00023294 and KY#00023315 were unsubstantiated; however, unrelated deficient practice was identified with the highest Scope and Severity (S/S) of a "D".	F 000		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure staff accurately documented on clinical records for two (2) of eight (8) sampled residents (Resident #4 and Resident #8). Staff documented providing fifteen (15) minute observation checks on	F 514		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/07/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 514	Continued From page 1	F 514		

Resident #4 while they were off the floor on a scheduled thirty (30) minute break and documented providing care for Resident #8 that was discharged from the facility.

The findings include:

Interview, on 06/04/15 at 4:55 PM, with the Executive Director (ED) revealed although there was not a policy related to maintaining clinical records, his expectations were all staff to follow protocol with documentation. They should be documenting task as soon as it is finished and not at the end of the shift.

1. Review of the medical record revealed the facility admitted Resident #4 on 05/28/15 with diagnoses which included, Dementia, Anxiety and Hypertension. A review of the admission assessment dated 05/28/15, revealed the resident was oriented to name only.

Review of the every (q) fifteen (15) minute checks log dated 05/29/15 revealed State Registered Nursing Assistants (SRNAs) #3, #12 and #14 documented q 15 checks while they were on their schedule thirty (30) minute break.

Interview, on 06/03/15 at 4:03 PM, with SRNA #12, revealed she left the floor for her thirty (30) minute break and did not have another staff member to observe the resident. Continued interview revealed she did sign off that, she did the q 15 checks and it was wrong to sign off on something she did not do.

Interview, on 06/04/15 at 12:32 PM, with SRNA #3, revealed he took his scheduled break from 10:30 AM to 11:00 AM on 05/29/15. Continued

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F 514	Continued From page 2	F 514		

interview revealed he would go outside at times for his break and would not be on the unit. Further interview revealed he should have asked another SRNA to observe Resident #4 and document his/her location while he was on break.

Interview, on 06/04/15 at 3:30 PM, with SRNA #14, revealed she did not check on the resident while she was on her break and did not ask anyone to follow up with the q 15 checks. SRNA #14 stated she didn't even know if the resident was checked at all while she was on her break. Further interview revealed she should never sign off on anything she did not complete herself.

2. Review of the medical record revealed the facility admitted Resident #8 on 04/17/15 with diagnoses which included, Aftercare for healing Traumatic Fracture of Hip, Alzheimer's Disease, and Anxiety.

Review of the Progress Note dated 05/25/15 at 8:15 AM, revealed Resident #8 was transported via stretcher by Emergency Medical Services (EMS) to the Emergency room.

Review of Treatment Administration Record (TAR), dated 05/25/15, 05/26/15 and 05/27/15 on evening and night shift revealed staff signed off on treatment which included, elevate heels off mattress, incontinent management, Prevalon boots to bilateral feet while up in chair every shift, and turn and position q two (2) hours by SRNA #4 and SRNA #1.

Interview, on 06/04/15 at 12:06 PM, with SRNA #4, revealed she was informed Resident #8 was sent to the hospital on rounds at the beginning of her shift on 05/25/15. Continued interview

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revealed she always signs off her work at the end of the shift in the treatment book and she did not pay close attention to what she was signing off. SRNA #4 stated she made a mistake and by signing off on work not completed was false documentation.

Interview, on 06/04/15 at 2:25 PM, with SRNA #1, revealed she worked the evening shift and received report regarding the resident's discharge status. Continued interview revealed she should always notice what she was signing and signing off on a discharged resident was false documentation.

Interview, on 06/04/15 at 4:31 PM, with the Director of Nurses (DON), revealed her expectation was for all staff to accurately document on all charting or any document provided by the facility. She stated staff should have been more aware and not charted on a discharged resident. Continued interview revealed she expected staff to chart as they completed their task if possible, and if not to document actual care provided.